Community Clinics and Neighborhood Health Centers:
An Overview of the Past Twenty Years

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Preface

I began this project with a long-standing interest in the history of, and major issues faced by, community clinics and neighborhood health centers in the United States over the past twenty years. My interest in this topic stems in part from my own work with one community clinic in Berkeley for several years and from my belief that those of us involved in alternative movements can learn from an understanding of our own history. It is my opinion that a historical perspective is all too often lacking in movements for social change.

Time and financial constraints have limited this paper to an analysis of the published literature. A few comments on the limitations of this approach are appropriate here.

Out of the incredible diversity of community clinics, I have discussed free clinics and local, neighborhood-based clinics in some depth. The organizers of free clinics frequently wrote about their efforts in the early years of the free clinics and the result is a rather large body of literature about these clinics in contrast to other community clinics. I have largely omitted discussion of clinics serving specific groups (for example, women's clinics and clinics serving an over-sixty population). These omissions should not be taken as an indication of the importance of particular types of clinics. They only
reflect the available literature. With particular reference to women's clinics, there is a great amount of material available about the women's health movement in general and a feminist analysis of the treatment of women in the medical care system. There are, however, remarkably few references to the large number of women's clinics founded in this country and in Canada in the early 1970's. There is one very informative, comprehensive study of the Vancouver, British Columbia Women's Health Collective, though this is not widely available (Kleiber and Light, 1978).

For the sake of clarity and also for the sake of writing about a manageable amount of material, I have focused specifically on those neighborhood health centers funded by the Office of Economic Opportunity, and later the Department of Health Education and Welfare. I discuss the later Rural Health Initiative and Urban Health Initiative clinics only briefly in the third chapter and I make only passing mention of any of the other federally funded clinics aimed at specific populations, including the Maternal and Child Health clinics.
Chapter 1

Introduction and Historical Background

Introduction

Neighborhood health centers and community clinics will be examined as unique institutions for providing health care in the United States. The last one and a half centuries have seen the increasing professionalization and specialization in health care in this country. Increasing professionalization is supported by strong legal sanctions. The last several decades have witnessed the increasing corporatization of the health care system. In the midst of major trends toward corporatization and specialization, a small but viable institution that runs counter to these larger trends emerged in the 1960s.

Neighborhood health centers and community clinics are unique because together they represent the only major attempt in the United States to provide comprehensive quality health care to the nation's poor by provision of direct services while simultaneously addressing the larger social problems of the communities they serve. Other publicly funded health services in this country, including public health clinics, county hospitals, and the Medicaid and Medicare programs, have not had the same aims. Public health clinics were set up in many areas of the country around the turn of the century, but the vast majority did
not provide treatment for any illnesses except tuberculosis and venereal diseases. County hospitals have been available in some regions as a last resort source of medical care for the poor. Such care has generally been fragmented and episodic rather than comprehensive in nature. It has been characterized by long waits in overcrowded waiting rooms and rushed, brief visits with clinicians, creating at least the impression of second-rate medical care. Certainly Medicaid and Medicare have accounted for the major part of federal expenditures on health care. These programs, however, only provide reimbursement for care at existing facilities and then only provide for coverage for certain groups of the poor considered worthy of public support: the disabled, the elderly, and single mothers and their children.

Neighborhood health centers and community clinics began in the middle 1960's at a time when prosperous white Americans were rediscovering poverty in their own country. Neighborhood health centers began as part of the Great Society, during an era of expanding federal spending for domestic social programs to combat poverty. Neighborhood health centers were begun not only to address the unmet health care needs of the poor, real as these were, but also to address many of the larger social problems associated with poverty, with the hope of using health centers as a basis for initiating broader social change. Community
participation in decision-making was mandated as an integral part of this approach. Community clinics, which generally were not substantially federally funded, began as part of the larger political and social movements of the 1960s. Community clinics generally began with goals similar to those of the neighborhood health centers. Their goals included providing accessible, respectful, high quality primary medical care to their communities or constituencies while also addressing the larger social and community problems not usually addressed by direct medical services.

Once federal funding for social programs began to decrease, neighborhood health centers found it difficult to survive. The federal funding of neighborhood health centers was an inherently unstable source of funds. This source was guaranteed only so long as the Administration and Congress were friendly to the Great Society programs and so long as increasing international commitments did not impinge on spending for domestic programs. By the very nature of their efforts, health centers could not be self-supporting or efficient at providing large numbers of patient visits per provider. Their financial problems began when President Nixon set about dismantling the War on Poverty programs.

The decreased popularity of domestic social spending affected community clinics as well. Community clinics, which were not federally initiated, nor wholly federally
funded, sought funding from a variety of sources and often operated on very skimpy budgets. However, they too were subject to similar pressures for self-sufficiency and efficiency as public support for local and state funding of social programs waned.

The origins of neighborhood health centers and community clinics set up a number of tensions. The tensions are not necessarily inherent in any attempt at non-commercial medicine but were a part of the structure and circumstances in which health centers and clinics originated. The most basic question is whether community clinics and neighborhood health centers can survive as an alternative institution within the existing health care system. In what form can neighborhood health centers and community clinics survive? The tensions partly arose from pulls between different interest groups. The different parties within the clinics and health centers had quite different interests in the projects. Organizers were interested in using the clinic or the health center as a basis for political power to initiate larger social change. Professionals were interested in providing health care services. Communities were often more interested in the employment opportunities created by the clinic than in the health services it promised to provide. While OEO mandated maximum feasible participation of local residents in both governance and employment, no one had more than a vague idea what form this participation
should take. Lack of clarity about governance led to conflict in the attempt to restructure the traditional professional hierarchy within the clinics. Clinics often faced opposition from local physicians, professional organizations and other representatives of the traditional health care structure. Both neighborhood health centers and community clinics found themselves in an inherently tenuous economic position. Health centers and clinics were forced to rely on government funding and were unable to become self-sufficient because the population they served could not afford to pay the cost of their care. This paper addresses two of the major issues that faced neighborhood health centers and community clinics: community participation and economic survival.

The first chapter provides a brief sketch of the historical context in this country in the middle of the 1960's, when both neighborhood health centers and community clinics had their origins. An overview of the Great Society programs is provided so that the reader may understand how the neighborhood health centers, funded by the Office of Economic Opportunity (OEO), fit into President Johnson's Great Society as a whole.

The second chapter traces the early history of the OEO-funded neighborhood health centers and the non-federally funded community clinics and summarizes the development of health centers and community clinics into the 1970's.
The third chapter focuses on two of the major issues faced by most neighborhood health centers and community clinics: the issue of community and consumer participation in governance and the issue of the economic survival of health centers and clinics, and how these concerns shaped the future of both the health centers and the community clinics.

The fourth and final chapter examines the question of what has happened to the clinics in the 1980's, especially with regard to their drastically changed economic situation and the changes in funding of social services, by tracing examples of a number of health centers and community clinics.

Definitions

Before moving on to discuss the historical background surrounding the development of neighborhood health centers and community clinics, it is necessary to define and distinguish these terms since they have distinct origins and were established on quite different scales of magnitude.

The term "neighborhood health centers" refers specifically to comprehensive primary care clinics that were funded by grants from the federal government, under the auspices of the Office of Economic Opportunity (OEO) and the Department of Health Education and Welfare (DHEW). These health centers were generally large, well-supplied, well-funded, and well-staffed facilities. Later, all of the neighborhood health centers were transferred to DHEW, and the neighborhood
health centers plus numerous smaller, less comprehensive clinics (the Rural Health Initiative and Urban Health Initiative clinics) were all re-named "community health centers". For the most part, this paper continues to use the term "neighborhood health center" even after the transfer, partly for consistency and partly because the focus is primarily on the original neighborhood health centers and not the later, smaller Rural Health Initiative and Urban Health Initiative clinics.

"Community clinics" is a term that will be used here to encompass all locally-initiated free clinics and community-based or neighborhood-based clinics. Most of these clinics were much smaller than neighborhood health centers and most began without substantial federal funding, though some later obtained partial federal funding.

Confusion arises in the terminology used to discuss the diversity of clinics that comprise the category of "community clinics". Smith, Bentel and Schwartz, for example, use the term "free clinic" in a generic sense and then specify "neighborhood type" and "street" or "hippie" types of free clinics.[1] Hayes-Bautista attempts to clarify the confusion by introducing the term "primary care clinic" as the general term in his work. He uses the term "free clinic" to refer to clinics oriented primarily toward the needs of white counter-culture youth. He refers to "community clinics" as those clinics oriented toward serving minorities
or underserved poor whites.[2] While his classification is useful, the term "primary care clinic" has not come into popular usage. Consequently, the term "community clinic" will be used here as the more general term, viewing free clinics as a subset of community clinics. Discussion about "community clinics" in general or specifically about "neighborhood-based" or "community-based" clinics will be clarified in context by using these three terms. In many cases the distinction between free clinics and community-based clinics has blurred over the past several years, but it is important historically because the two groups of community clinics served different populations with different priorities. Many community-based clinics initially did not want to be associated with the free clinics, which were perceived as serving only "hippies" and drug addicts and not addressing the needs of ethnic communities.

**Historical Background**

Before discussing the early history of the neighborhood health centers in the next chapter, an overview of the historical context of the domestic social programs of the 1960's will be presented so that the reader may understand the unique context in which neighborhood health centers and community clinics arose. The development of these clinics was made possible by the national focus on poverty, the belief that health care is a right, and the willingness
of the nation to direct substantial federal funds toward solving domestic social problems.

The early and middle 1960's saw the rediscovery of poverty and racial injustice by both middle America and the elite in this country. This occurred in the midst of one of the greatest expansions in technology and in available products and services in our country's history. In the midst of plenty, the prosperous white citizens of this country rediscovered poverty and racial discrimination. The Supreme Court under Chief Justice Earl Warren had begun moving toward striking down the legal basis for racial discrimination in some realms by the middle of the 1950's. John F. Kennedy was shocked by the poverty he saw while campaigning for the presidency in 1960 and was also influenced by writings such as Michael Harrington's *The Other America*. [3] However, Kennedy's administration had little success in achieving passage of many of his social programs and it was not until Johnson took office that the War on Poverty really began. [4]

A crisis in health care was recognized along with the rediscovery of poverty in the midst of plenty in the middle 1960's. The crisis in health care was seen in terms of a realization that a large number of people in both urban and rural areas did not have access to medical care they could afford. The lack of access to health care was recognized in the context of tremendous technological
developments, advances in research, and expansion of medical education and hospitals in the post-World War II period. How should the country provide access to health care for all of its citizens? The definition of the health care crisis changed dramatically over the subsequent two decades, but in the 1960's the definition of the crisis as the lack of access to adequate, affordable health care led to the development of Medicaid, Medicare, neighborhood health centers and other programs. The development of these programs was predicated on a recognized lack of access to health care and the need to redress the resulting inequality both for reasons of economics and because of humane concerns for personal dignity. The view that health care should be a right and not a privilege enjoyed significant support at that time.

The 1960's and on into the early 1970's was a time of many active social movements in this country. The late 1950's and early 1960's saw a growing civil rights movement. By the middle 1960's there were riots in many of the black ghettos in many urban centers across the country. The movements to redress racial injustice developed increasingly militant components. The late 1960's and early 1970's gave rise to a strong anti-war movement opposing our country's long, drawn-out military involvement in Viet Nam and other parts of Southeast Asia. The same period of time saw the "flower children" and the "hippies" of the Haight-Ashbury
and other urban areas, accompanied by a growing drug culture among white and black youths, and increasing questioning of authority and tradition, particularly by the youth. This era also gave rise to a stronger women's movement than had been seen at any time since the first two decades of this century. The women's health movement and women's clinics established along feminist principles were an integral part of the feminist movement. The Stonewall riots of 1969 marked the beginning of the gay rights movement. There were many other popular trends of the same period, including increasing awareness of the importance of environmental preservation, concern about pollution, and a growing consumer awareness about products and services purchased. These broad-based and diverse trends were very important in providing the climate for the development of non-government sponsored community clinics, including free clinics, community-based clinics, and women's clinics.

When Lyndon B. Johnson assumed the presidency in the aftermath of Kennedy's assassination he was successfully able to press through Congress the Civil Rights Act of 1964, War on Poverty legislation, and his own Great Society plans. Much of this legislation was passed in the two years of 1964 and 1965. In his first State of the Union message on January 8, 1964, President Johnson declared, "The Administration today, here and now, declares unconditional war on poverty in America."[5] The following excerpts
from President Johnson's speeches give the flavor of the
enthusiasm with which the "Great Society" programs were
undertaken. President Johnson first spoke of a Great Society
on May 2, 1964 at the University of Michigan commencement
exercises:

"Your imagination, your initiative, and your indignation
will determine whether we build a society where progress
is the servant of our needs, or a society where old
values and new visions are buried under unbridled
growth. For in your time we have the opportunity
to move not only toward the rich society and the powerful
society, but upward to the Great Society.
The Great Society rests on abundance and liberty for
all. It demands an end to poverty and racial injustice,
to which we are totally committed in our time. But
that is just the beginning...
But most of all, the Great Society is not a safe harbor,
a resting place, a final objective, a finished work.
It is a challenge constantly renewed, beckoning us
toward a destiny where the meaning of our lives matches
the marvelous products of our labor.
So I want to talk to you today about three places
where we begin to build the Great Society - in our
cities, in our countryside, and in our classrooms..."

A month later, on June 26, 1964, President Johnson had
this to say at a Democratic Party fundraising dinner in
Detroit:

"In 1960, in this city, John Fitzgerald Kennedy began
his campaign for President. He asked you then to
make a choice for progress. You made that choice.
The result has been four years of unmatched progress
in this nation...
No one will stop America from wiping out racial injustice
and liberating every citizen, of every race and color,
to share in all the blessings of our freedom. No
one will stop America from feeding the hungry, and
caring for the helpless, and giving dignity
self-respect to the old..."

In this address, President Johnson spoke of using the federal
budget to encourage and expand investment in material and human resources as the core of the poverty program.

"Our war against poverty seeks to give the desperate and downtrodden the skills and the experience that they need to lift themselves from poverty. We are going to pass this program, and in our lifetime we, God willing and with your help, are going to wipe out poverty in America."[8]

The War on Poverty programs proposed increasing social insurance payments, expanding public assistance, and providing food, housing and health programs to provide for the most basic needs of people living in poverty. The Economic Opportunity Act (EOA) was passed in 1964 and created a number of programs to eliminate both the causes and consequences of poverty.[9] Although never amounting to more than about one eighth of the money the federal government spent on the poor in this period, the Economic Opportunity Act was in many ways the cornerstone of the War on Poverty.[10] This legislation was particularly distinct in that it had the goal of providing opportunities for people to help themselves get out of poverty rather than simply providing increasing assistance to the poor while maintaining them in poverty. The Economic Opportunity Act initially established several programs with this goal in mind: the Community Action Program, Head Start, VISTA, Legal Services, Adult Basic Education, the Neighborhood Youth Corps, Job Corps and the Work Experience and Training Program. The Office of Economic Opportunity (OEO) was established to administer these programs created by the Economic Opportunity Act.[11]
The goals of the "Great Society" were broader still. The aim of the Great Society programs was to use the federal government to correct social inequality and make a minimum standard of living available to all citizens.[12] The federal government was seen as an appropriate mechanism for making such changes and Johnson was quite willing to commit the government and the nation to such action. The Great Society programs for fighting poverty included the expansion of income support programs, health care programs, low income housing, federal aid to education, manpower programs, civil rights legislation, as well as the programs under the auspices of the Office of Economic Opportunity discussed briefly above.

The income support programs of the Great Society were largely inherited by the Johnson administration from previous administrations. Veterans programs, worker's compensation, and Social Security programs (including old age insurance, benefits to survivors and the disabled, and unemployment compensation) were all established in the 1930's or earlier. The food stamp program was initiated more recently, during the Kennedy administration. The growth of income support in the 1960's was primarily an acceleration of previous trends rather than the establishment of new programs. Categorical public assistance programs, which include Aid to Families with Dependent Children, Old Age Assistance, Aid to the Blind and Aid to the Permanently and Totally
Disabled, were all established in the 1930's. It is these categorical public assistance programs which represented the largest area of growth from 1965 to 1970.[13]

The bulk of federal funding for health care programs went into Medicare and Medicaid, both established in 1965. In addition, funding was approved for maternal and child health, educational expenses of low income medical and dental students, community mental health centers, and research into cancer and heart disease. Federal health expenditures, which had been $2.9 billion annually in 1963, rose to $13.1 billion by 1969.[14] Part A of Medicare finances hospital costs for the elderly while Part B finances physician and ancillary expenses. Medicaid was established as a federal program matched by state funds to provide health care benefits to those persons eligible for categorical public assistance.[15]

Low income housing was made possible by the Housing and Urban Development Acts of 1965 and 1968. The Housing and Urban Development Act of 1965 established the Department of Housing and Urban Development (HUD). This act, together with the Housing and Urban Development Act of 1968, made the federal government a major factor in the housing market. These acts established low interest government loans and interest subsidy programs on private loans for construction of low income housing, as well as assistance for low income families to purchase homes.[16]
In the middle 1960's, equal opportunity in education was believed to be the key to equal economic opportunity. Federal aid to education expanded substantially in the 1960's with particular focus on improving opportunities for disadvantaged students. Other education programs included Head Start, which provided early education opportunities and care for pre-school children, and programs to provide financial assistance to college students from low income families.[17]

Manpower programs included increases in minimum wages and specific programs to provide education, training, and job placement for those who were chronically unemployed. Part of the Great Society's vision was full employment.[18]

The Office of Economic Opportunity (OEO), discussed above, was the office administering a number of War on Poverty programs established by the Economic Opportunity Act of 1964. One of these programs was the Community Action Program, itself an umbrella for several programs.

The Community Action Program (CAP) was distinct from other anti-poverty programs because it contracted with local non-governmental groups to implement local anti-poverty efforts. Furthermore, community participation in development and delivery of services was to be a fundamental concept of these programs. As stated in the Economic Opportunity Act, these programs were to be "developed, conducted, and administered with the maximum feasible participation of
the residents of the areas and the members of the groups served."[19]

A variety of community action agencies working on diverse projects came under the CAP umbrella. Services provided included early childhood education, social services, job training, health care, housing, and legal services. Funds were used to establish neighborhood health centers, Head Start projects, community development corporations, manpower centers and various cooperatives.[20] Thus CAP incorporated a wide range of activities. The initial idea was to distribute funds to local organizations and let them decide how to spend the money. However, very early on, a large proportion of these funds were already earmarked for specific purposes and the earmarked proportion increased with time. In 1965, forty percent of CAP funds were earmarked for Head Start projects, and by 1971 eighty percent of CAP funds were earmarked for specific types of projects.[21]

Health services was not one of the major areas in which the Office of Economic Opportunity initially planned to fund projects.[22] However, it was with funding through the Community Action Program within OEO that the neighborhood health centers began. CAP general funds provided funding for the first eight neighborhood health centers as demonstration projects in 1965. In the following year, the 1966 amendment to the Economic Opportunity Act earmarked specific funds
for additional neighborhood health centers. A unique attempt to address the crisis in health care had begun.
Chapter 2

Early History of Neighborhood Health Centers and Community Clinics

To understand the nature and development of the major issues that faced neighborhood health centers and and community clinics it is necessary to know something of their early history. Neighborhood health centers and community clinics are distinct entities in terms of their origins and development and thus deserve separate attention.

Neighborhood Health Centers

The Community Action Project of the Office of Economic Opportunity (OEO) funded the first proposal for two neighborhood health centers in June 1965. CAP funded a third center two months later, and five more projects later in the same fiscal year.

H. Jack Geiger and Count D. Gibson, both professors at Tufts University College of Medicine at the time, submitted the first proposal to OEO for developing a health center at the Columbia Point housing project in Boston. This proposal was to be a model for comprehensive neighborhood health centers to serve the needs of people in poverty. The initial proposal was expanded to include two centers, one in Boston, and the other one in Mound Bayou, Mississippi, a rural Southern area. Both centers were designed to provide a full range of out-patient health services to residents
of the designated communities. The centers were proposed to employ community residents in many functions and to include the community in operation of the health centers.[1] Jack Geiger describes the purpose of the centers as outlined in this first proposal:

"The first health center proposal to the Office of Economic Opportunity thus stated its purpose was 'to intervene...in the cycle of extreme poverty, ill health, unemployment and illiteracy by providing comprehensive health services, based in multi-disciplinary community health centers, oriented toward maximum participation of each community in meeting its own health needs and in social and economic changes related to health.' The proposed health services were to 'include preventive, curative and health education programs in new patterns of medical care organization.' They were to 'emphasize the formation of community health associations...to stimulate change in family and community knowledge and behavior relating to the prevention of disease, the informed use of available health resources, and the improvement of environmental, economic and educational factors related to health.' "[2]

Eight neighborhood health centers were funded in fiscal year 1965 as research and demonstration projects as part of the Community Action Program. The Columbia Point and Mound Bayou projects were funded in June 1965. Approximately two months after the Columbia Point and Mound Bayou proposal was funded, a proposal for a neighborhood health center in Denver was funded. Five more proposals to OEO for neighborhood health centers were funded in the next several months, including Martin Luther King Health Center in the South Bronx, Mile Square Health Center in Chicago, and the Watts Health Center in Los Angeles.[3]
There was, however, no explicit funding for health programs as part of OEO until the following year, 1966. Explicit authorization for funding neighborhood health centers was made possible in large part due to the efforts of Senator Edward Kennedy of Massachusetts, who became an early supporter of the neighborhood health centers. He was concerned about the health problems of children enrolled in Head Start programs and was impressed by the potential of neighborhood health centers to provide health care for the poor. In 1966 he proposed and amendment to the Economic Opportunity Act that set up a neighborhood health center program with funds earmarked for that purpose.[4] The passage of this amendment greatly expanded the authorization level and the number of projects that could be funded. The amendment provided funding specifically for comprehensive health care in urban and rural poverty areas. Fifty million dollars was appropriated for neighborhood health centers for 1967 under this amendment.[5]

With the funding of eight neighborhood health centers in 1965 and the authorization of specific funds for health centers with the 1966 amendment to the Economic Opportunity Act, the Community Action Program within OEO began to develop and articulate the goals and characteristics of neighborhood health centers. Fundamental to the program was OEO's attempt to insure maximum feasible participation of residents of the areas and members of the groups served by health centers.
Sar Levitan discusses a four point model for comprehensive neighborhood health centers that was developed by CAP at this time:

"(1) a full range of ambulatory health services; (2) close liaison with other community services, which implied referrals and exchanges of services; (3) close working relationships with a hospital, preferably one with a medical school affiliation; and (4) participation of the indigenous population in decision-making that affected the center and, whenever feasible, their employment in subprofessional and other positions."[6]

Lisabeth Bamberger Schorr and Joseph T. English discuss seven basic characteristics of neighborhood health centers as they were initially envisaged by the staff of the Community Action Program. These seven characteristics, presented here, are quite similar to the model Levitan presents:

"1. Focus on the needs of the poor.
2. A one-door facility, readily accessible in terms of time and place, in which virtually all ambulatory health services are made available.
3. Intensive participation by and involvement of the population to be served, both in policy making and as employees.
4. Full integration of and with existing sources of services and funds.
5. Assurance of personalized, high quality care, and professional staff of the highest caliber.
6. Close coordination with other community resources.
7. Sponsorship by a wide variety of public and private auspices."[7]

While neighborhood health centers were established as part of the War on Poverty, the impetus for the health centers and origin of the concept came from progressive health professionals.[8] The reader will recall from the first chapter that health services was not one of the major areas in which OEO initially planned to fund projects. It
was these progressive health professionals who saw the deficiencies in health services for the poor and believed that the solution to this problem lay not in pumping more money into existing services but in setting up a different system to provide accessible primary care health services to the poor. In conjunction with this, many of the people involved in the early development of neighborhood health centers saw health centers not only as a change in health care delivery to the poor but also as a basis for organizing other social changes in the circumstances of the poor.[9]

This kind of perspective led many health centers to attempt to incorporate a variety of other social services besides just traditional delivery of medical services into their projects.

It is important for the reader to have an understanding not only of the origins and goals of neighborhood health centers but also of some basic descriptive material about their organization and function to understand to problems that arose.

During the first year of OEO's existence, eight neighborhood health centers were funded. As of August 1968, thirty-two neighborhood health centers were in operation and an additional sixteen had been funded and were in the planning stages, for a total of forty-eight funded centers.[10] By 1970, 49 neighborhood health centers were located in 37 different areas in 23 states. About three fourths of
these projects were in urban areas and one fourth were
in rural areas.[11] By the end of 1971, more than 100
centers were receiving funding through OEO. Between 1968
and 1975, fifty-five additional centers were funded through
DHEW.[12]

The original goal of neighborhood health centers was
to provide a broad range of family-oriented ambulatory
health care services to people living in a defined area.
All of the centers provided basic general medical and laboratory
services. As of 1974, 94 percent of centers offered pharmacy
services, 90 percent had x-rays available, 99 percent offered
dental services and 80 percent offered home health services.[13]
The scope of additional services varied widely. Counseling
and social support services have generally been strong.[14]
Many centers became involved in outreach efforts, environmental
health activities, and other non-medical but health-related
activities.[15] Mound Bayou Health Center in Mississippi
found that malnutrition was one of the major health problems
in its region. Therefore this health center helped organize
a farm cooperative so that the primarily poor, black families
living in this area of Mississippi would have enough to
eat.[16] Many neighborhood health centers also provided
services such as transportation to and from appointments
or to and from inaccessible hospitals, child care services,
and health education for their patients.[17]
In 1967, the Office of Economic Opportunity estimated that the annual cost of providing health care at a neighborhood health center would be about $125 per person. The actual costs that year ranged from $85 per person per year to about $170 per person per year at Columbia Point in Boston.[18]

Initially all residents of a poor neighborhood health center were to be eligible for the center's services without charge. The standard was criticized by physicians and others who thought that only those residents who were actually poor should be eligible for the center's services.[19]

In 1967, Congress passed an amendment to the Economic Opportunity Act which limited free care at the health centers to "low income" residents. "Low income" was defined by OEO policy as the poverty index or the particular state's Medicaid eligibility income standard, whichever was higher.[20] In 1969 the interpretation of this law allowed for development of partial payment plans designed for people with income only slightly above the poverty index.[21] However, the same policy in 1969 also limited full-payment or partial-payment registrants to 20 percent of the total number of registrants.[22]

Estimates of the number of people served by neighborhood health centers are difficult to find and generally based on soft data. A 1976 study of the neighborhood health center program estimates that at the time about 1.5 million people were being served by neighborhood health centers,
including those centers originally funded under OEO plus those begun under DHEW.[23] Jack Geiger states that by 1982 there were 872 health centers serving 4.2 million people.[24] (This figure includes the large number of smaller and less comprehensive health centers established by DHEW in the 1970's.)

In 1965, the first year of OEO's operation, $2.0 million was allocated for neighborhood health centers out of an $18.8 million dollar OEO budget. The following year (1966) the OEO budget approximately tripled to $59.0 million, with neighborhood health centers allocated $7.8 million of this. In 1967 the OEO budget doubled to $117.7 million while the proportion allocated to neighborhood health centers increased almost seven-fold to $50.8 million. However, in 1968 both the total budget for OEO and portion allocated to neighborhood health centers dropped substantially. The OEO budget dropped to $99.5 million, with neighborhood health centers comprising just about a third of this total at $33.2 million.[25]

Beginning in 1968, the Department of Health Education and Welfare (DHEW) also began funding some neighborhood health centers and related local projects. Both OEO grants and DHEW grants to health centers continued to climb from 1968 to 1971. OEO grants to neighborhood health centers rose from approximately $33 million in 1968 to $51.1 million in 1969, $72.3 million in 1970 and $91.6 million in 1971.
DHEW grants began at $6.7 million in 1968, about doubled to $13.8 million in 1969, almost doubled again to $26.2 million in 1970 and more than doubled in 1971 to $63.8 million.[26]

However, the time of expansion quickly came to an end and the Nixon administration soon began dismantling the War on Poverty programs. Between 1970 and 1973 all of the neighborhood health centers were transferred to DHEW from OEO. Neighborhood health centers began to feel the beginnings of increasing pressures to become self-sufficient. This discussion will be taken up again in the next chapter.

The issue of sponsorship of health centers is an important one in reference to the discussion of community participation in the next chapter. All neighborhood health centers that received OEO or DHEW funding had both an agency that applied for and received the grant to establish the health center, called the grantee, and an agency (usually not the same agency) that administered the funds, called the administering agency. While most of the early grantees were community action agencies (32 out of 48 programs in July 1968), these community action agencies were also the administering agencies in only two of these 48 health centers.[27] (Community action agencies refer to the local CAP agencies.) Operating control was generally maintained by the administering agency. Hospitals, medical schools, and health departments made
up two thirds of the administering agencies in 1968. [28] Thus in the early history of most health centers, funds were actually administered and operational control retained by agencies within the health care system.

The same general trend in sponsorship continued through 1971 and applied to both OEO and DHEW funded health centers. However, by 1971 some changes were beginning to be visible. Approximately 10% of health centers in 1971 were administered by "other agencies" (which includes community action agencies), and "new health corporations" administered approximately one third of both OEO and DHEW health centers. [29] Some of these "new health corporations" included both community participants and professionals. Thus a slow shift toward community agency control of the operation of neighborhood health centers could be seen by this time. [30]

**Community Clinics and Free Clinics**

The Haight-Ashbury Free Medical Clinic opened its doors on Clayton Street in San Francisco in June of 1967. It is generally considered the first free clinic and was the first clinic opened to address the particular needs of young people arriving in increasing numbers in certain urban areas, living on the street or in very crowded conditions, and increasingly involved in the use of a variety of drugs. [31]

In the spring of 1967, several medical students drafted a proposal to establish a free medical clinic in the Pruitt-Igoe housing project in St. Louis, Missouri. A 1966 census
showed 10,546 residents in this project, almost all of whom were black. Nearby medical care was very insufficient for the population of this project. This clinic was one of the first student-initiated health projects. The students, working in conjunction with the Pruitt-Igoe Men's Progressive Club, opened this clinic in June of 1968.[32]

A number of free clinics were founded in a variety of settings from 1967 to 1969. In October of 1967 the Open Door Clinic opened in Seattle, initially to deal with drug abuse problems, but it rapidly expanded to include general medical services. Two student-initiated clinics were formed in late 1968 in Durham, North Carolina (Edgemont Community Clinic) and Chapel Hill, North Carolina (Chapel Hill-Carboro Family Health Clinic) by students at Duke University and the University of North Carolina. Edgemont Community Clinic was situated in a 60-block area of deteriorating tenements with a population that was about 60% black, while the Chapel Hill Clinic was in a rural area of 45,000 with a population about 24% black. A number of other student-initiated projects followed, including two set up by students at Loma Linda University in southern California for migrant farm workers. The Robert Taylor Clinic was established in July 1968 by residents of the Robert Taylor Housing Project in Chicago with the support of the Student Health Organization of Chicago. A rural free clinic was established in Taos, New Mexico in February
of 1969. The Berkeley Free Clinic was established in May, 1969 after several months of planning that had begun in October of 1968. The Black Panthers and other political groups were also involved in establishing clinics. The Black Panthers established and financed clinics in Los Angeles, Portland, Seattle, Philadelphia, Chicago, New York and Boston. In Los Angeles, the County Health Department became involved in sponsoring free clinics, beginning with the San Vicente Youth Clinic (1968) and eventually including sponsorship of six clinics in that county.[33]

According to the National Free Clinic Survey, approximately 70 free clinics were established in the years 1967 to 1969. The first six free and community-based clinics opened in 1967, located in San Francisco, Cincinnati, Detroit, Seattle, Vancouver, B.C., and Toronto, Ontario. In 1968 a number of clinics opened in several cities, some of them discussed above, including Los Angeles, Atlanta, Boston, St. Louis, Chapel Hill, Durham, Chicago, Washington, D.C., Las Vegas, Portland, Denver, Philadelphia, Minneapolis, Bellevue, Champaign, Montreal and Winnipeg. A total of 28 clinics opened in 1968 and 36 more in 1969, for a total of 70 clinics by the beginning of 1970. During the year 1970 approximately 70 more clinics opened, approximately doubling the number of free clinics in that year alone. By the end of 1970 there were free clinics in 26 states plus the District of Columbia and at least three Canadian provinces. Twenty
additional new centers opened in the first three months of 1971.[34]

Both free clinics and community-based clinics were usually organized by health activists, including especially young physicians and medical students. In addition, a number of militant political groups established clinics, including the Black Panthers and the Young Lords.[35]

Free clinics and community-based clinics generally began with a philosophy of providing accessible free or low-cost medical care. Free clinics were often established because physicians or other health professionals recognized that the local counter-culture youths had a number of health problems related to drug abuse, mental illness and crowded, unsanitary living conditions.[36] Community-based clinics were usually established when someone, again often a physician, students, or a political organization recognized the lack of adequate, accessible health care in a particular neighborhood, housing project, or rural area.[37]

Free clinics considered themselves free not only in the sense of not charging for services but also in the sense of being free of much of the usual structure of providing health care. Paperwork to determine eligibility for free services was avoided and the clinic strucuture was often "free" in the sense of avoiding a hierarchical structure. The atmosphere of the clinic was casual and there was a clear attempt to create an environment where young members
of the counter-culture could feel comfortable obtaining needed health care. Conscious efforts were made to treat patients respectfully and not judge their lifestyle or dress pejoratively. The free clinics saw a number of patients with drug overdoses and "bad trips", but many of the health problems of their patients were much more general. Patients sought treatment for skin infections, minor wounds, respiratory tract infections, gastrointestinal disturbances, hepatitis, and gynecologic problems. Patients came in with psychological concerns, and with requests for contraceptives and pregnancy counseling.[38]

Smith, Bentel and Schwartz attempt to define "free clinics" (used in the generic sense) as including the following characteristics:

"1. Direct delivery of either medical, dental, psychological, or drug care.
2. Presence of a professional relevant to the service provided.
3. Services available to everyone.
4. In general, no direct charges (although small charges for specific services or donations may be requested).
5. Specific hours of service.
6. Care provided from a specified facility."[39]

However, it should be clear from the above discussion that free and community-based clinics attempted to be much more than just a free source of medical care.

The free clinics served primarily white adolescents and young adults, who were members of the counter-culture and often were drug users or drug abusers. The counter-culture or "hippie" movement appealed primarily to white, middle
class teenagers and young adults, and the clinics serving this group initially attracted a similar population. Their clients came not only from the immediate neighborhood but come from all over the city and even further away. A significant proportion were transients. [40]

Most neighborhood-based clinics, in contrast, would see patients more representative of their immediate community, for example the residents of the Pruitt-Igoe Housing Project. They would generally see a wider age range of patients as well, seeing both more older adults and more children than the free clinics. [41]

Some clinics found that their clientele changed significantly over time. For example, the Baltimore People's Free Medical Clinic began by serving members of the largely white counter-culture but over the first 18 months of their operation, people in the local neighborhood began looking at this clinic as their primary health care facility. The clinic evolved to operate as a community facility. [42]

Community clinics were founded, grew, flourished, and sometimes closed in a variety of settings throughout the country. The remainder of this section provides a general base of information about free clinics and community clinics, including summaries of services offered, characteristics of the populations served by these clinics, and in the case of free clinics, information about staffing and the cost of providing services.
First, however, a comment about the limitations of the literature in this area is in order. Summary information about community clinics is scant at best. Therefore this section relies heavily on one national survey of free clinics and three reports on community clinics in California. In 1971, Jerome Schwartz published a national survey of free clinics (both "street" and "neighborhood" clinics) founded from 1967 to 1969.[43] The survey covered the first seventy free clinics and was the most thorough study that has been published. Survey data for community clinics in California is available in three reports, two presented by the Department of Health Services and one by David Hayes-Bautista.[44] Several articles on individual clinics in the 1970s, some of which are quite thorough, are available.[45]

Of the first seventy free clinics studied by Schwartz, fifty-nine provided medical care. Ten clinics provided only psychological services and one provided only dental care. For those clinics offering medical care, such care was available an average of 14.5 hours per week, ranging anywhere from only three or four hours a week to more than 25 hours per week.[46]

Basic medical services were available in most or all of the clinics operating a medical clinic. First aid, treatment for acute illness and treatment for venereal disease were available in most or all clinics. Prescription
drugs and laboratory tests were also available in most of these clinics. A number of other services were provided by a majority of clinics, including infant care, child and teenage health care, immunizations, pregnancy testing, family planning, abortion counseling, and drug education and/or drug counseling. Just half of the clinics reported providing social services. A wide range of other services were offered by some clinics. These included psychological counseling, pre-natal and post-natal care, drug detoxification and rehabilitation programs, dental care, operating a crisis telephone line, vocational guidance, draft counseling, and legal services.[47]

The clinics that Schwartz calls "street clinics" served primarily white adolescents and young adults from a middle class background, mostly in their late teens or early twenties, who were often involved in the drug culture. What he calls "neighborhood" clinics were more likely to serve minority group clients, with a much wider age range, including older people, young children, and pregnant women. Neighborhood clinics tended to have a large population of black patients. Eighteen out of twenty-three neighborhood clinics surveyed by Schwartz saw at least forty percent black patients and eleven of these saw eighty to one hundred percent black patients. Two clinics had eighty percent Spanish-speaking patients. Four programs with more than half white patients served an Appalachian white population.[48]
Free clinics utilized a wide range of staff, including physicians, nurses, lab technicians, pharmacists, medical students, lay medics or community aides, psychiatrists, social workers, psychologists, lay counselors, and office, janitorial, and administrative personnel. Most of the staff working in free clinics, especially the professional staff, were volunteers. Community aides and secretaries were the most likely to be paid, whereas only a few clinics paid physicians or other professional staff members.[49]

"Almost all clinics were formed without funding; in the beginning all staff members are volunteers. After donations are received or a small grant secured, salaries are paid to a few staff members. However, the salaries are generally low, whereas the hours worked and donated are very large."[50]

The cost to the clinic to provide a single visit in 1972 ranged from $.80 at Berkeley Free Clinic to $3.50 at Cambridgeport Medical Clinic. These low costs were possible because the staff volunteered their time and many of the components of the overhead were often donated. These costs do not include the value of donated staff time, nor the value of donated facilities, supplies, and medications.[51] At the People's Free Medical Clinic in Baltimore, a single visit, exclusive of donated professional services, cost about $2.50 in 1977.[52]

The Association of California Rural Health Centers (1983) identifies several characteristics usually associated with what they call "community sector" clinics. These are non-profit clinics providing community-based primary
care services. They generally have a community-based board of directors, emphasize prevention-oriented health care, provide health education services, have a commitment to providing culturally sensitive health services, utilize mid-level practitioners, allied health professionals and community health workers, offer support services such as transportation, translation, and day care, consider environmental health factors, and finally are committed to working with the community to reduce barriers to health services, including financial, cultural and geographic barriers.[53]

The Office of County Health Services' (of the Department of Health Services) study of community clinics and free clinics in California reports that in 1980 there were 380 licensed community clinics and free clinics in California. Sixty percent of these were general medical clinics and 26% were family planning clinics, with the remaining 14% including various other types of clinics. They found community clinics or free clinics in 49 of California's 58 counties. Seventy percent of the general medical clinics were located in areas designated as medically underserved by the state. In 1980, community clinics and free clinics provided almost 4.3 million visits to about 1.3 million patients.[54]

The general medical community and free clinics in California provide a wide range of services. Most of these clinics provide all the basic ambulatory care services:
primary care, gynecology, pediatrics, pre-natal and post-natal care and family planning. Most also offer health education, nutrition education, and other preventive and social services. Over half provide outreach services and other services to improve accessibility, such as transportation. Most family planning clinics in California offer family planning services, gynecology, and treatment for sexually transmitted diseases. A majority provide health screening and health education and some also provide primary care.[55]

Community clinics and free clinics in California serve primarily a low income and ethnic minority population. Over half the patients seen at general medical clinics have incomes below the poverty level and almost all have incomes below twice the poverty index. Most are not covered by health insurance and cannot afford to pay for their health care in full. While about a third of the patients at general medical clinics are on MediCal, over 40% are classified as "medically indigent" and are not on MediCal. (In California, "medically indigent" refers to people who are not eligible for MediCal, do not have insurance, and cannot afford to pay the full cost of health care.) Sixty percent of patients at general medical clinics are members of ethnic or racial minority groups, including blacks, Latinos, American Indians, and Asians. Over a third of the people seen at general medical clinics speak a language other than English as their primary language.[56]
This chapter has traced the funding of neighborhood health centers and community clinics, the circumstances in which they originated, and the initial goals they set out to achieve. Information about the basic characteristics of health centers and community clinics, the services offered, and the population served has been outlined. In the case of neighborhood health centers, background information about federal expenditures and sponsorship has been presented.

The next chapter will examine two major issues that have faced both neighborhood health centers and community clinics almost universally: the issue of community and consumer participation and the issue of economic survival of neighborhood health centers and community clinics.
Chapter 3
Major Issues Faced by Neighborhood Health Centers and Community Clinics

With a background of the Great Society programs, the social context of the time, and the early history of the health centers and community clinics, this chapter will address the major issues that faced neighborhood health centers and community clinics. It is particularly striking that the two major issues of community participation and economic survival faced both neighborhood health centers and community clinics almost universally, despite their different origins. Certainly there were other concerns and problems, but most of the problems could be traced to the issues of economics or community participation in governance.

Community Participation in Neighborhood Health Centers

One important aspect of the initial goals of neighborhood health centers was that the centers were to insure participation of the community and the health center users in the governance of the health centers. Fundamental to the program was OEO's attempt to insure maximum feasible participation of residents of the areas and members of the groups served.[1] The implications and importance of the requirement of consumer participation was not initially perceived by early planners.
within OEO or by founders of the early neighborhood health centers.[2]

However, the issue of the extent of consumer participation and the degree of community control in neighborhood health centers emerged as one of the major internal and even structural conflicts within neighborhood health centers. This problem was probably second only to the obvious and overwhelming problem of a stable and long-term economic base for neighborhood health centers. The issue of community participation has an important basis in the structure of neighborhood health centers and an important component of historical context. Neighborhood health centers were started in the midst of the civil rights movement and at a time when the more militant aspect of the movement for black power was gaining popularity. Further, the issue of community participation as it evolved in neighborhood health centers has important implications for professionals and academics working with community-based organizations in the future.

A number of problems developed around the general issue of community participation. First, most health centers were planned and funded without any community participation. Second, once community participation was sought by the planners, the role of community residents in the health center was usually very unclear to both the professional staff and the residents themselves. Third, who represented "the community", and therefore what constituted "community
participation" was often not at all obvious. The combination of some or all of these three components often led to quite heated conflict over control of the neighborhood health center.

As was discussed earlier, most neighborhood health centers were originated by health professionals and most of the early neighborhood health centers were sponsored by a hospital, medical school or county health department that administered the health center. The lack of adequate health care has only been one of many problems facing the poor living in urban ghettos and rural communities. For many of the poor in the 1960's and 1970's, the lack of health care ranked well below many other concerns. Jobs, housing, education, and police actions were often more primary concerns in urban areas.[3] In rural communities such as Bolivar County in the Mississippi Delta, hunger, lack of safe drinking water, lack of sanitation, lack of habitable housing, and lack of jobs were of higher priority for the residents than lack of medical care.[4] Yet in most cases, professionals saw the lack of health care in a community as a priority, obtained sponsorship and an OEO grant to establish a neighborhood health center and only then sought community involvement in the project. In so doing, they attempted to impose a kind of instant participation on the community with only a vague idea of the form this community participation should take.[5]
What was not recognized at the time was the extent to which after-the-fact community involvement can never make up for participation of residents in the planning process. [6] This is especially important in light of the fact that health care was often not perceived as a top priority by many poor communities. May, Durham and New state that,

"the early project directors assumed that they shared with the community the common goal of developing a needed health service program. Moreover, they felt that their commitment would cause the community to ignore any short-term miscalculations." [7]

To further explain the perspective of the project directors, May, Durham, and New quote from an interview with Robert Tranquada, an early director of the Watts Neighborhood Health Center, who said,

"'I think we thought of ourselves as being some kind of knights in shining armor who were good enough to sacrifice some part of our career to this, and we were very much affronted when it became apparent very early on the community did not trust any further than they could throw us. They didn't trust us that much. This was a very, very difficult thing for us to understand.'" [8]

The stories of Columbia Point Health Center and the health center sponsored by Montefiore Hospital are two typical examples of such beginnings. Jack Geiger has discussed how at Columbia Point Health Center in Boston the university (Tufts) had already drawn up plans for the program without participation of community representatives. The university then sought to instantly create such participation and to do this they tried to find community representatives and create an ad hoc community committee as quickly as
possible. The staff from Tufts met with community residents at a series of 50 meetings in residents' apartments to explain the health center. Out of this an ad hoc committee of residents was formed which evolved into a lay health association.[9]

When Montefiore Hospital and Medical Center was awarded an OEO grant in 1966 to provide medical care for a 55 square block area of the South Bronx, they opened a storefront office in the community to explain the program to residents. Again, the health center had been planned by professionals living outside the area. These storefront meetings as well as meetings in apartments, laundromats and restaurants attracted only a few people. The staff learned that health care was a low priority compared to other problems in the area and that residents looked on the staff with skepticism and mistrust.[10]

A third example of a much less typical beginning follows. Tufts University also received an OEO grant for a second neighborhood health center at Mound Bayou in Bolivar County in the Mississippi Delta. Here, long before health services began, a team from Tufts launched a full-scale community organization effort. Their staff knocked on nearly every door in northern Bolivar County with the resulting formation of ten local health associations in different communities in the 500 square mile area.[11] A longtime resident of Mound Bayou later described the suspicion with which she
initially viewed the white men from Tufts coming to her church. The church members told the staff from Tufts that they didn't care about a health center. They needed food, clean drinking water, sanitation, liveable houses and jobs. The staff from Tufts listened and what resulted was that the Tufts staff assisted the community in developing a farm cooperative and also worked on digging wells, constructing outhouses, and repairing housing as well as establishing a clinic.[12] However, the approach at Mound Bayou differed considerably from the approach at most of the neighborhood health centers, whose development is more typically described by the stories of Columbia Point and Montefiore.

The establishment of community boards was delayed for at least two reasons. First, there was a great deal of pressure, both from OEO and from within a project's own administration, to begin to provide clinical services as quickly as possible.[13] Second, neither OEO nor the delegate agencies had a clear idea of how a community board should function or what it was to do.[14]

The role that community residents were to have in the center's operation was very unclear to both the professional staff and the residents themselves. For their part, most health professionals, including liberal physicians interested in social change, were not accustomed to consumers and
community residents telling them what to do. As Count D. Gibson has pointed out,

"For many health professionals, the notion that members of the community served by a health program should somehow be involved in its operation is an utterly absurd proposal. If coerced, they may reluctantly agree to an advisory board, but it soon becomes clear to the community and to the institution that health professionals are simply not accustomed to taking advice from the laity."[15]

Once a community board or advisory committee was formed, it also had very little sense of its own function and power. Initially, newly formed community boards were often satisfied to provide advice on relatively minor issues such as paint color, furniture and hours of operation. This was often fine with the staff and directors who did not envision community boards taking a major decision-making role.[16] But eventually, sometimes very early on and sometimes much later, the community board members often concluded that they should have more control over the center's operation and fundamental policy decisions. As the board attempted to define its role conflict often resulted, frequently focusing on the project's director, and in some cases even leading to the director's resignation. Such conflict was often centered around the issue that the board felt that professionals were trying to take the center away from them.[17] Once community boards realized that their function was only that of a rubber stamp with little real power they began to challenge their professional sponsors. This
often led to angry confrontation, as Gordon discusses,

"During this period of strife, anger flares and threats are made. The responsible community representatives demanding real responsibilities and power and the young militants demanding recognition threaten to sabotage the project through boycott or even violence ... Meanwhile everyone's attention is diverted from patient care."[18]

Often adequate training about how to work with each other was distinctly lacking for both community board members and professional staff. Community members often lacked training in managing fiscal affairs and making technical and medical decisions. Professionals usually lacked training in community organizing and effective communication. Promises of training programs frequently never materialized.[19]

Hatch and Eng discuss the problems of simply placing poor people on community boards without any training:

"The assumption that representation of the poor on neighborhood boards would insure access to and influence upon decision-making was not enough to remove the critical barriers for improving quality of care. Simply to place poor people on boards of health care programs and expect them to compete with the traditional health care industry was foolhardy. They frequently lacked certain technical knowledge and resources, as well as the accepted language with which to gain even more."[20]

Third, there is the issue of who represents the community. Who represented "the community" was often much less than obvious for several reasons. Often the area served by a single neighborhood health center did not constitute a single community in the geographic sense of the word.

The Mound Bayou Neighborhood Health Center served at least ten smaller communities or population clusters.[21] Areas
that might be a single community geographically were frequently not homogenous groupings of people. Such a mixed community might have different sectors with varied interests and priorities.[22]

Further, planners of neighborhood health centers often regarded poor black communities as if they had no internal organization or community structure. Since they did not recognize the existing local structure and leadership, they made no attempt to utilize the existing internal organization. Rather, they imposed an artificial selection structure on the community from the outside. Indeed, recognized community leaders were often prohibited from running for election to the community board or advisory committee. Elections frequently showed a very poor turnout, and, because of this, often favored the selection of more militant or particularly well-organized factions that might not represent a substantial portion of the community.[23] Hatch and Eng discuss the topic of community participation as follows,

"Much of the confusion at the community level can be traced to the unrealistic, and at times wild, criteria used to identify local leaders. In some cases respected and influential members of the community, such as schoolteachers, preachers, and funeral directors, were categorically excluded from participation...Instead, those individuals who generated the most steam and who were the most militant were too often perceived by OEO Washington administrators as being community leaders. In many cases, they tended to hold policy positions on boards far beyond their actual base of grass-roots support...Strategies such as these frequently resulted in disabling communities rather than strengthening them, as advocates of these actions had surely intended. As struggles for influence and control within service
delivery organizations intensified, staff professionals often became the scapegoats."

Later in the same article, Hatch and Eng discuss how projects often ignored existing community structure and the results of this ignorance:

"OEO programs were often planned as if poor communities had no viable social organization or structure. They, therefore, sought to create or sanction new structures rather than to conduct a hard analysis of what existed. In addition to ignoring the existing leadership and local decision-making patterns, long-established social-support networks were overlooked. For example, Community Action Program guidelines stipulated that community participation be brought about by forums, discussions, nominations, block elections...These traditional democratic means frequently appeared absurd because they were so alien to the traditional community mechanisms for eliciting involvement. In some communities, when elections were held, nobody voted...Maximum feasible participation as interpreted by OEO staff sometimes did more to divide communities than to bring them together."[25]

Yet despite numerous problems, direct community influence in neighborhood health centers did increase. In 1969, control of the Watts Neighborhood Health Center was transferred from the University of Southern California to the health center's community board. This served as an important example to other health centers and ultimately significant control was transferred to the community boards of a number of neighborhood health centers.[26] As we have seen, by 1971 an increasing number of grants for new health centers were going to community agencies and new health corporations with community involvement. The neighborhood health centers that survived found mechanisms for community boards and
professional staff to work together, not necessarily out of love, but at least out of a common goal.

Economic Survival of Neighborhood Health Centers: The Dismantling of OEO and After

The 1970's witnessed a trend of decreased willingness of the federal government to fund social programs that began when Nixon came into the Presidency. This trend resulted in pressure on neighborhood health centers to become self-sufficient and more efficient in their operations. The increased funding for health centers during the Carter administration went not into expanded funding for comprehensive neighborhood health centers but rather went to establishing numerous smaller, less comprehensive clinics. Under the Reagan administration neighborhood health centers have experienced serious cutbacks. In 1982 alone over a quarter of health centers were entirely defunded.

As we have seen earlier, neighborhood health centers under the auspices of OEO were established as part of the War on Poverty program of the Johnson administration. The Nixon administration wanted to eliminate many of the social programs established during the Johnson years and decrease the role of the federal government in direct funding of social programs. As part of its efforts to dismantle the War on Poverty, the Nixon administration set about dismantling OEO and transferring its remaining programs to other agencies. Between 1970 and 1973 all of the
neighborhood health centers that had been funded under OEO were transferred from the jurisdiction of OEO to that of the Department of Health, Education and Welfare (DHEW).[27]

In 1973 the Nixon administration attempted to require neighborhood health centers to become "self-sufficient", that is independent of federal funding. Despite the failure of this attempt there was continued pressure on neighborhood health centers to become more self-supporting by obtaining increased third party payments.[28] (The problems with this approach to self-sufficiency will be discussed later in this section.) Neighborhood health centers were pressured to become more efficient in their operations and the use of professionals where community members had been employed previously was encouraged.[29] Under DHEW there was no longer any funding for staff training. For the next several years the Nixon and Ford administrations requested cutbacks both in the number of health centers and in their level of federal support. The Ford administration attempted several times to transfer responsibility for neighborhood health centers to the states. Congressional opposition and support from within DHEW prevented significant cutbacks. This meant that funding remained at a relatively constant level despite inflation and rapid increases in the cost of health care during this period.[30] Neighborhood health centers continued to eek out a survival throughout the mid-1970's.
In 1975, Congress approved (over Presidential veto) legislation to set up a categorical grant program for neighborhood health centers. This legislation renamed neighborhood health centers as "community health centers" (CHC's) and funded the program at considerably higher levels than neighborhood health centers had been funded at in the preceding several years. The categorical grant legislation also specified how community health centers should be organized and specified what services were mandatory for them to provide and what additional services they could choose to provide. The mandatory, or primary, services included physician, laboratory and x-ray services, transportation, preventive health, and dental services. The supplemental services that could be provided included nutrition education, health education, social services and outreach. However, the monies allocated by this program did not go into increasing funding for existing health centers or toward establishing new neighborhood health centers, but rather went primarily toward establishing a large number of smaller, less comprehensive, and more traditional health centers. Initially these health centers were entirely in rural areas. These were the Rural Health Initiative clinics, which began in 1975 under the Bureau of Community Health Services (BCHS). (BCHS was the name of the bureau within DHEW responsible for administering the categorical grant monies to fund community health centers.) These clinics were on a much
smaller scale than the OEO clinics and many more were funded. In 1975, 47 Rural Health Initiative clinics were funded. The next year 138 RHI clinics were funded. In 1977 the total rose to 262 clinics and by 1978, 356 RHI clinics were being funded. Thus the emphasis was shifted away from urban poverty and shifted toward the need for basic medical care in rural areas.[31]

Beginning in 1977, BCHS also began to fund Urban Health Initiative clinics (UHI's), which were clinics in urban areas established on the same principles as the RHI clinics. In 1977, 35 UHI clinics were funded. Both the Urban and Rural Health Initiative clinics had relatively small budgets and their mandate was to provide quality basic medical care. Community health services such as health education, outreach services and environmental health activities, which had been an important aspect of the original neighborhood health centers, were seldom funded for Urban and Rural Health Initiative clinics. Grants were generally given to hospitals, county health departments, or other existing providers. Generally these programs made heavy use of National Health Service Corps personnel to staff their clinics.[32]

Under the Reagan administration, the existing level of services offered by health centers, consumer participation, and indeed the very existence of health centers have been greatly threatened. Reagan's general approach has been
to decrease the proportion of the federal budget that goes to social programs and to increase the proportion going to the military in the name of "defense". In 1982, Reagan attempted to convert categorical grant programs such as that for community health centers to block grants to the states, allowing states to decide what to do with the money. Congress indeed passed block grants but established one that was specifically earmarked for primary care. This Primary Care Block Grant gave states the option of taking over responsibility for community health centers but also set up various disincentives so that very few states actually exercised this option. Nevertheless, 1982 saw a 25% cut in the funding of health centers, in addition to the impact of inflation, Medicaid cuts and cuts in the National Health Service Corps program which provided staff for many centers. In 1982 alone, 239 of 827 health centers were defunded by the federal government. Those remaining were often forced to further limit their services and curtail any community health services that remained in their programs.[33]

Funding Dilemmas

Whatever the conflicts over community participation and control have been and however much these conflicts were built into the structure of the health centers, it is the success or failure to find consistent, stable sources
of funding that determines whether neighborhood health centers survive or not.

First, neighborhood health centers never had a stable basis of federal funding with a strong constituency. Funding for health centers has been very much subject to changes with changing administrations in Washington and changing economic and political climates. Part of this lack of a stable economic base is due to the initial establishment of neighborhood health centers as a demonstration program. Neighborhood health centers were funded to demonstrate a model for health care, with the assumption that neighborhood health centers would be able to be self-sufficient in the not too distant future. This belief was predicated on the assumption that neighborhood health centers would be able to obtain substantial reimbursement through Medicare, Medicaid, or national health insurance. When self-sufficiency was not feasible, the inevitable questions arose of how many demonstrations were necessary for the government to fund to demonstrate a model of health care. Daniel Zwick, an early OEO administrator, addressed the initial assumptions about long-term funding for neighborhood health centers in an article he wrote in 1972:

"The initial OEO grant support of health centers assumed that long-term financial support would come largely from Medicaid, Medicare and other financing sources. The organization of the centers, in turn, would make it possible to achieve better use of the increased funds available for health services. These assumptions appeared reasonable in the mid-1960's; new large-scale federal health financing programs had been enacted
about the same time as the first grants were awarded
to health centers...The nature and growth of the Medicaid
programs has frustrated the achievement of this goal.
State programs have been restrictive with respect
to both beneficiary eligibility and supported services.
Benefits have been reduced rather than expanded."[34]

Further addressing the problem of financing health centers,
Zwick concludes that:

"Sound long-term financing arrangements for the centers,
and other health programs for the poor, depend upon
major changes in national health financing programs."[35]

Rather than witnessing the major changes that Zwick
believed were necessary, neighborhood health centers found
themselves under increasing pressure to become self-sufficient.
Health centers were put in an impossible situation. As
of 1969, health centers were only allowed to have 20% of
their registrants above the poverty level. Poor people
obviously could not afford to pay for their own medical
care. Rather, Medicaid and Medicare paid for medical care
for certain categories of poor patients. However, attempts
to obtain reimbursements through Medicaid and Medicare
met with little success. Alice Sardell has discussed some
of the problems health centers have had with Medicaid and
Medicare reimbursements in her 1983 article:

"One of the major reasons that health centers have
been unable to be self-sufficient institutions is
that Medicare and Medicaid are biased against them
as providers of care and against the delivery of community
health services as opposed to traditional medical
care. Medicare, for instance, did not recognize community
health centers (CHC's) as reimbursable providers until
1973, and has only granted recognition to centers
which have very sophisticated accounting procedures...A
1977 study of Medicaid reimbursement found that only
twenty-two states and the District of Columbia
recognized community health centers as 'clinics' and reimbursed them for services provided. A 1981 update of this study found only a slight increase in the number of states that reimbursed health centers as clinics. Even when community health centers are reimbursed as clinics under a State Medicaid plan, they are not likely to be reimbursed for all of the services that they provide to their patients."[36]

Eventually restrictions on the population that neighborhood health centers could serve were removed, but the original problems remained.[37] Health centers found themselves under increased pressure to obtain third party reimbursements and to charge clients with incomes above the poverty level on a sliding fee scale. Most neighborhood health centers are located in poor neighborhoods and serve a population living primarily below or near the poverty level. Attempts to bill low income clients, who often have no health insurance, pose both practical and ethical concerns. Pressures to charge for visits, even on a sliding scale, may discourage some clients from using the clinic. In addition, many clinics have found that many of their poor clients are not eligible for Medicaid or Medicare.[38]

Neighborhood health centers and other community health centers have found themselves under increasing pressure to become more efficient. This resulted in the elimination of training funds and a movement away from hiring local residents who required training.[39] Employment of local residents had been one of the most popular aspects of the health center in many communities.[40] Neighborhood health centers were instructed to hire only trained personnel.
and each center was to meet established goals for productivity.[41]

"Each center receives guidelines for meeting certain fixed goals - the number of patients seen by physicians and other professionals per hour, the ratio of nonmedical to medical staff, the proportion of costs allocated to direct health care, the number of health professionals per registrant."[42]

Guidelines were standardized for all neighborhood health centers and were based on data from medical practices serving a non-poor population. They did not take into account the need for and importance of education, counseling and outreach, nor any of the special difficulties of serving a rural population or a population with increased health care needs. Funding decisions have come to be based on evaluation of how well such efficiency criteria are met.[43]

The push for efficiency has resulted in the elimination of many paraprofessional positions and increased pressure to see a large number of patients in a short time, eliminating some of the most valuable services offered. Many health centers have had to cut back their services to the minimum mandatory requirements.[44]

Such an emphasis on increased efficiency may lead to significant losses in achieving the original goals and purposes of the neighborhood health centers to provide comprehensive health services. As Alice Sardell points out,
"Reagan Administration policies up to 1983 have further diminished the capacity of existing health programs to provide the community health services that were central to the original health center model. The irony in this account of...the federally funded community health center program is that a President whose rhetoric is about local initiative and returning power to communities is the one whose Administration has attempted to destroy a program based on these principles." [45]

Structure and Control of Community Clinics

The early free and community-based clinics were generally founded by health professionals, much as the neighborhood health centers were. Many of these clinics were firmly committed to breaking down traditional relationships between professionals and staff and operating within a non-hierarchical structure. The issue of community participation takes a different form than with neighborhood health centers. In the case of free clinics, it was often difficult to define a "community" at all, and once defined, this community of young drug users often had no interest at all in involvement in the clinic's affairs. Neighborhood-based clinics, however, usually found early and significant community participation to be a strong asset.

Many of the early free and community-based clinics were begun by health care professionals and community activists.

"A number of Street clinics are 'run' by a professional who started the clinic, generally the self-appointed medical director, but sometimes the administrator or other professionals. Most of these clinics were organized around the drug problem and cater to young persons." [46]
David Smith, a young physician in San Francisco in 1967, was a key figure in the founding of the Haight-Ashbury Free Medical Clinic. A nurse named Jeanne Sonville launched Cleveland's free clinic in 1970 by treating young people with drug problems in her home. Medical students at George Washington University established the clinic at Pruitt-Igoe housing project in St. Louis in conjunction with a local club of residents at the housing project. The People's Free Medical Clinic in Baltimore was founded by a coalition of women's movement and anti-war movement organizations in Baltimore in 1970. Individuals already active in Planned Parenthood, the Burlington Free Clinic and local feminist groups, as well as health professionals, founded the Vermont Women's Health Center in 1972.

Many of these early clinics were committed to developing a clinic with a non-hierarchical structure. Some, such as the Vancouver Women's Health Collective, operated as a collective of all staff members. Schacter addresses the commitment of the Baltimore People's Free Medical Clinic to a less hierarchical structure:

"In the free clinic tradition, it had a mandate to provide health care in an atmosphere free of the usual stereotyped roles for nurses, physicians, aides, and patients. An attempt was made to demystify the physician's role, to provide patient education, to bring non-physician health workers into the decision-making process, and to allow nonprofessional workers to upgrade their training roles and responsibilities to the limits of their abilities."
Stoeckle addressed the same issue five years earlier (1972):

"...their miniature size, seldom more that three to six rooms and the volunteers they recruit make their staff a more egalitarian, peer organization in which the hierarchical differences among professionals are played down, and clinical work easily exchanged between nurses, doctors, students, pharmacists, social workers, ex-patients and local volunteers."[53]

The role of consumer or community participation in community clinics is an important issue but a complex one that is not made any simpler by the great diversity of circumstances of different clinics.

In many of the free clinics addressing drug-related problems it was difficult to define a "community" and even if defined there was often very little interest on the part of young drug abusers in participation in the operation of the clinic. Many of the lay volunteers at clinics were themselves ex-patients but there was often little interest in participation on the part of the clinic's general population. Schwartz addresses this:

"It is difficult, however, in the street type clinic to define the community. The transient youthful runaway or adolescent with drug problems does not want to take part in policy making. The lay staff members, often recruited from early patients or street people believe they represent the 'community', which may well be true."[54]

Based on his survey of free clinics, Schwartz found that in about forty percent of clinics there was no significant consumer participation, however defined.[55] Stoeckle also addresses this issue of consumer participation in free clinics in his 1972 article, citing the lack of formal
consumer participation as one of the key differences between neighborhood health centers and free clinics:

"...unlike health centers, few free clinics have formal community participation. Some may have a lay-professional board... These boards can help raise money and protect the clinic, sanctioning it to police and licensing agencies, who often want it removed because of its attraction for 'undesirable' people... Thus, community participation in the clinics tends to be minimal, and their running is rather in the hands of those who staff them — people personally involved who together organize these cooperative ventures from 'shoestrings', seeking out youth and minorities to learn from them what help is needed and then working at providing what treatment, if any, is possible."[56]

However, the situation has usually been quite different in neighborhood-based community clinics. Neighborhood community clinics, serving primarily poor and or minority group residents, have generally been community controlled from their inception by policy-making boards composed of local residents. Those clinics with active consumer or community participation have found it to be very important to their project.

"Centers with active consumer participation have found it to be important to the program — important in breaking down communication barriers between the patient, the professional, and the lay staff member. Consumer participation opens channels so that patients can voice their criticisms, concerns, and suggestions about the program. And more important, the patient's ideas and criticisms have a greater chance to be acted upon toward improving the program."[57]

William Harvey addresses the importance of community involvement in the planning of clinics to serve a minority community:

"The establishment of the minority free clinic usually begins with a small group of dedicated individuals
who recognize the need and have faith in their ability to meet this need. Among these individuals, one is likely to find students, social-health professionals, political activists, and other concerned citizens. It would be ideal if this individual group contained 'community people,' i.e., persons who live in the area to be served. Unfortunately this will not always be the case. However, it is absolutely essential that among the prime movers in the group be individuals with the same racial characteristics as the group to be served... A number of planning meetings have to take place. If the community people are not already represented, some must be brought in at this point. This particular group is likely to evolve into the governing board, and community people must constitute a majority of the body. It becomes quite a healthy exercise to formally air the goals and motives of the initiators of the project during one of the early sessions."[58]

Other authors have expressed similar sentiments regarding the importance of community participation in the clinic's early development. Hayes-Bautista's work suggests that governing boards of community clinics in California are representative of the communities they serve, at least in terms of ethnic composition. He found that in 1980 about half (51.7%) of the governing boards of community-based general medical clinics were members of ethnic and racial minorities. In the same category of clinics a similar percentage (56.1%) of patients were members of ethnic or racial minorities.[59]

Student-initiated clinics that did not have firm ties with the community and did not learn to work with their communities ran into problems very quickly because of this. The founders of the Pruitt-Igoe clinic found that because they chose to work with one particular club of residents
that was not representative of the housing project as a whole, this created problems later when the club members did not want broader community representation on the board of directors.

"Although active community involvement is essential to the successful operation of a clinic such as ours, the degree of community representation and participation in our clinic has been less than we had hoped for originally. In part this may reflect the community group that we worked with...Since the opening, the Men's Club has hesitated to extend community representation on the board and argued that community involvement would draw 'community wreckers' who would destroy the clinic. Although other factors may have been involved, it now seems apparent that the Men's Club members desired to preserve the prestige that they had obtained through their exclusive association with the clinic; the clinic was their achievement."[60]

**Economic Survival of Community Clinics:**

**Financing of Community Clinics**

Most community and free clinics began with minimal funding, relying substantially on volunteer staff and obtained the small amount of funding they had from a variety of sources. Many clinics found that they could not survive long-term on an all-volunteer basis. They found it necessary for their internal organizational stability to have at least a small core of paid staff.

As was discussed earlier, most community clinics and free clinics were opened with very minimal funds and, at least initially, relied very heavily on volunteer staff to provide services. Many clinics had an all-volunteer staff. In 1972, the cost per visit of providing health
care ranged from $.80 a visit at Berkeley Free Clinic to $3.50 per visit at Cambridgeport Medical Clinic. In 1977, the People's Free Medical Clinic (Baltimore) figured their cost per visit at approximately $2.50. None of these figures include any estimate of the value of labor donated.

Free and community-based clinics have obtained what little funds they have had from a variety of sources. These sources have included state and local governments, donations from patients, grants from private foundations, and contributions from area residents and businesses. Contributions have been obtained by canvassing, panhandling, or soliciting monthly pledges. The donations of time, material, and facilities have been crucial to the very existence of many free and community-based clinics.

At the time of Stoeckle's article (1972), the Cambridgeport Medical Clinic obtained its funds through support by a private foundation. Their only paid staff were the secretaries. In 1977, the People's Free Medical Clinic in Baltimore, with a budget of approximately $32,500 annually, obtained support primarily from donations by patients and contributions from area residents in the form of monthly pledges. Almost from its inception, the Berkeley Free Clinic raised money by collecting donationns in red cans on the streets of Berkeley. One can still see staff collecting money for the Free Clinic daily at the corner of Telegraph
and Bancroft Avenues. In 1970 their budget was only about $1100 per month, well under $14,000 per year.[65]

The twenty-five free clinics included in the Office of County Health Services report in 1980 in California reported that a total of 68% of their funding came from federal, state, or local (including county) grants or contracts. Twenty-four percent of their funding came from contributions, including donations and other fund-raising efforts.[66] General medical community-based clinics in the same study received over 40% of their funds from federal grants and contracts alone and over 20% of their funds from state and local grants and contracts. However, about half of these clinics received no federal money, and about half received no state or local money.[67] Patient revenues, including both direct payment and third party payment made up the only other significant category. MediCal, Medicare and insurance made up 22% of revenues. It is significant to note that direct patient payment made up 10% of revenues when one remembers that half of the population served have incomes below the poverty level and most have incomes below 200% of the poverty level.[68] Contributions and foundation funding made up very small percentages overall. This is in contrast to the importance of contributions for the free clinics.

Since most clinics began with next to no money, they generally opened with an all volunteer staff. However,
the issue of having at least some paid staff soon proved quite important to the stability of free and community-based clinics. The Haight-Ashbury Free Medical Clinic found by 1970 that there was no substitute for having some paid staff:

"Whatever success the Clinic has had with its various programs has resulted from the determined and dedicated efforts of a few key personnel, who have been on salary. Granted that the operation of these programs would have failed without the many good-hearted volunteers, nevertheless, it has been the salaried people who have kept things going—have kept a structure alive that volunteers could fit into."[69]

The Berkeley Free Clinic also believed by 1970 that voluntary free clinics could not continue to be effective indefinitely without a core of paid staff:

"The implementation of the Clinic's objectives has been a significant example of what can be done on a voluntary, community basis to reach an otherwise inaccessible population. But, the experimental phase is over and the voluntarism upon which the Clinic has had to depend will, in part, become self-defeating. Professional workers and members of the community will continue to give of their time, but the Clinic must be able to maintain a paid, core staff and operate on a more stable budget. A history of community clinics has shown that they cannot continue to be effective of they must depend entirely on voluntary services."[70]

By 1980 in California, community-based clinics paid 72% of their medical staff while 28% remained volunteer. Free clinics paid 53% of their medical staff while 47% were volunteer.[71] Thus it is clear that by 1980 there was a general trend towards increasing the proportion of paid staff. Attempting to maintain a clinic on a long-term basis with an all volunteer staff proved to be a tenuous
proposition at best.

**Funding Dilemmas**

Funding has posed a continual dilemma for free and community-based clinics. On the one hand, there is a clear, obvious need for a stable source of funding for clinics. However, any source of funding, be it federal, state or local monies, or foundation grants, inevitably shapes the course of the clinic to some degree. Intake and eligibility procedures are often required and obtaining particular sources of funding may result in an emphasis on particular services or a particular clientele. The funded services and clientele may not be the services that the founding staff or board members were most interested in providing nor the clientele they intended to serve. This situation poses a dilemma for clinics, especially the clinics which are strongly committed to political goals and have a strong activist stance. Initially, many free clinics had hoped to stay free of the "establishment", though in retrospect this was clearly an impossible task. Many clinics felt that by seeking and accepting government grants or contracts they would be forced to sacrifice their goals and would become another structure supporting the existing health care system, rather than an organization trying to change this system. Rosemary Taylor has discussed this dilemma from the perspective that clinics accepting government
money allow themselves to be co-opted and indeed that free clinics may not be an appropriate means of trying to initiate social change:

"Free clinics saw their service as a means both to improve health care and to promote a movement for medical and social reform. Ironically, they may win the tolerance of local communities and lay claim to federal funds because they inadvertently dampen that movement. The most obvious way in which free clinics can act against the political mobilization of a neighborhood is in directing the energy of the people they attract as patients and workers into the all-consuming work of service delivery. Patients receive treatment and some relief and their attention is diverted from the systemic problems that caused their physical ailments. Radical organizers get so caught up with the daily trials of keeping the clinic open that they have no time to devote to combatting the agencies which set priorities and policies in the health care sector...Free clinics, then, may inadvertently facilitate the co-optation of leaders of political movements."[72]

Harry Clark presents a contrasting viewpoint on the subject of outside funding in a speech on the topic of the relevance of free clinics for blacks. He argues that not just federal funding, the concerns about which were much publicized in the free clinic movement, but any funding, can co-opt clinics, but that it also is not possible to remain altogether outside the existing system. He advocated a strong national coalition of free clinics as a bulwark against these dangers. Attempts were made at such a coalition but they quickly fell apart at the Second Annual Symposium of the National Free Clinic Council in 1972. Though somewhat lengthy,
the following excerpt from his speech exemplifies this perspective:

"...most blacks in the alternative health structure movement recognize that a union of the multi-faceted communities is a necessary complement in dealing with the multibillion dollar national network of vested interest groups known as the traditional health institution...As long as a free clinic is economically dependent upon extra-communal sources, then it is subject to the possibility of external intervention into or influence on the internal politics of the clinic...this phenomenon is equally applicable regardless of the funding agency, be it government, federal, state or municipal, or foundation. The community must decide on the level of involvement, if any of external vectors in its affairs...the federal government portends no greater threat to the individual clinic than any other monetary source. However, if an agency were to fund a number of clinics without the individual clinics being cognizant of the extent of that agency's involvement, then that agency would be in a position to affect a significant portion of the movement; this possibility necessitates a national structure which could monitor the influence of external vectors on the movement...the free clinic, to be utilized by the black community as an instrument of health care delivery, must exist, be accessible to the community, and be subject to the internal whims of the community. Consequently, if the free clinic movement abandons these requisites in the adventurous quest of ultraradical ideology, then it becomes irrelevant to the physical needs of the black community..."[73]

As we will see in the next chapter, the free and community-based clinics that survived found ways to reconcile their political and social objectives with their indisputable need for funding to be able to continue to provide basic health care services.
Chapter 4
Community Clinics and Neighborhood Health Centers in the 1980s

What has happened to community clinics and neighborhood health centers in the 1980s? Are they all dead or dying? The impression that emerges from the few articles published since 1980 is that community clinics and neighborhood health centers are definitely not a thing of the past. It is true, however, that clinics have been struggling for their continued existence in the 1980s. Many have closed and many more have cut back services or no longer offer free medical care.

There is still a crisis in health care but this crisis is differently perceived now than it was in the middle to late 1960s. At that time the crisis was that health care should be a right and not a privilege. In the midst of plenty, over twenty percent of the population lived in poverty. Most of these people and many more people living slightly above the poverty line went without health care, often leading to chronic health problems that interfered with obtaining education and employment. Community clinics and neighborhood health centers were set up to address these problems, and even further, community health was perceived as a means to empower poor communities and give their residents greater control over their lives.
In the 1980s our government no longer believes that health care is a right and the crisis in health care is perceived quite differently. The crisis in health care is how to control the costs of health care that have spiraled out of control in the past decade, and, as a part of this question, how to make cost effective choices about applications of new technologies. Often the government sponsored health programs of the 1960s and 1970s are seen as the cause of rapidly rising government spending on health care. Geiger (1984) summarized the Reagan administration's attitude toward government funding of health care in general and health centers in particular:

"In the face of Reaganomics and the current administration's social (or antisoical?) policy, one must first question whether health centers even have a future. Not if the administration has its way, surely, for the attempt now is to abandon the very social commitments that constitute their foundation, to deny that health care is a right, to refuse the special needs of the poor by excluding them from the roster of the 'truly needy,' and to substitute the economic fiction that health care is a rational marketplace that will respond to classic market forces."[1]

Two authors have published studies demonstrating that government funding of community clinics and health centers can be part of the solution rather than part of the problem. In 1982, Freeman et al. argued that the Federal and state governments should expand funding of community health centers because they effectively serve many inner city and rural low income communities and have considerably improved access to health services.[2] By improving access, they demonstrated
that community health centers considerably reduce the patient population in hospital ambulatory clinics and emergency rooms, with considerable cost savings. (Emergency room care is very expensive to provide, especially when a large proportion of emergency room patients are there for non-emergency needs.) Thus community health centers can actually control health care expenditures. This argument, though supported by solid evidence, has not enjoyed much popularity.

Hayes-Bautista in 1983 advocated that state and local governments work closely with existing community sector clinics in California since, at least in California, these clinics serve a large proportion of the "medically indigent" population.[3] (In California, counties have the responsibility to provide medical care for the medically indigent as the provider of last resort.) The state has shown little promise of taking his recommendations seriously. A few counties in California, such as Alameda County, have undertaken such cooperative plans.

Geiger addresses the cutbacks in funding of neighborhood health centers that occurred in 1982 and the probable need for repeated mobilization of the constituency of health centers if they are to keep their doors open over the next several years:

"The cuts have already occurred; more than 200 health centers have been closed, and most of the others are struggling desperately to maintain services for their patients despite severe budget reductions. But the
attempt to include health centers in state-run block grants has, at least for the present, been fought off. And that victory is significant, for it demonstrated that health centers have an active and potentially powerful constituency, one that will most likely have to be mobilized again and again during the next few years. During that time, there will be only one political agenda for health centers: mustering the political support to stay alive and relatively independent, even if both the numbers of centers and the size of their budget is reduced."[4]

In an interview in 1982, Dr. Katherine Lobach, the director of the Comprehensive Family Care Center in the Bronx, discussed the funding cuts of 1981 and 1982 and how these reductions had affected her clinic:

"Then President Reagan came in and began his cutbacks...After all the trauma and everything else...finally on January 1 we were given a final notice to phase out the community health center program in two months...That whole business started in September, and hard on the heels of it we got word that the Maternal and Child Health people were also considering defunding projects, including us. In the end, though, they decided to give us a 15 percent budget cut, which affect children's service; we lost the adult services grant entirely...the sliding fee scale for adults is gone - if there's no subsidy, you can't have one. If you want to use the Health Center now and you don't have Medicaid, you have to pay the full amount...Because we didn't lose the children and youth grant, we're still using the sliding fee scale for children; there's still no charge for children's preventive services..."[5]

This health center did not discontinue their adult services with the loss of thier funding for adult health care, but they did begin charging the full price for all adult patients not on Medicare or Medicaid. The health center had begun as a center for children and youth, and children and youth continued to make up about two-thirds of their patients; they were able to maintain this grant.
Waitzkin (1983) argued that community clinics can be an appropriate focus for community organizing activities but that clinics remain isolated and vulnerable without any unified health care system to incorporate them. Since it is necessary for clinics to obtain support from outside sources, some clinics have attempted to protect themselves by obtaining revenue from several sources. Waitzkin discusses this strategy with reference to La Clinica de la Raza in Oakland:

"Only about 21% of the clinic's annual income has derived from patient-generated revenues, including both private and public insurance. Many of the clinic's clients have been among the working poor, who lack private insurance yet do not qualify for public programs. Other patients have come to the United States illegally...it has been impossible to maintain the level of services without financial support from external sources. Seventy-nine percent of annual revenues have come from outside funding agencies, which include federal, state, and local government as well as private philanthropies. By obtaining grants from different sources, La Clinica has protected itself from the dangers of dependency on any single agency. However, many of these grants have had a term of 2 years or less and have been subject to cuts based on the changing policies of government and philanthropic agencies. Almost all external funding is contingent on the preparation of extensive reports documenting the services provided...To meet these provisions, clinics must use the time and energy of staff members in activities that funding sources demand but that may not be related to clients' needs."[6]

The story of one community clinic in the coal town of Gary, West Virginia, population 3000, in 1983 is not an unusual one. Unemployment rose to 90% in this town and 30% in the surrounding area following layoffs by U.S. Steel in 1982.
"To continue serving these people the primary care clinic had to become essentially a free clinic, providing care without regard to ability to pay. This plunged it from financial self-sufficiency into deep deficits...The clinic stayed open largely because of the sheer determination of its administrator, Martha Chapman, and the staff. 'We'll see patients till there's nothing to see them with,' she said..."[7]

One clinic in Bedford Stuyvesant found that their services were continually eroded by reductions in federal grants. The effects of this gradually became visible over time. This clinic found that, in particular, eliminating home visits eliminated a crucial link with their patients. They recently reinstituted some home visits, especially in cases where environmental factors are considered important to the patient's health, despite budgetary constraints.

"Without such visits, a clinic like ours was inevitably on a downward spiral. Patients could not be adequately treated when their environment was ignored. The number of missed appointments soared, and the clinic responded by overscheduling...Waiting times grew longer, and more patients became discouraged and stopped coming...The clinic is now attempting, within its severe budget constraints, to reverse this process. In conjunction with the reinstitution of home visits the staff gives regular attention to patient complaints...A free category has been re-established and the program is attempting to reduce or eliminate lab fees and pharmacy charges."[8]

More recently, community health centers have been hit with the skyrocketing malpractice insurance rates and decreased coverage that are affecting other parts of the health care industry as well. This is the latest financial problem to hit the community health centers, and some have already closed their doors, decreased services, or increased their fees because of it. This excerpt from The New Physician,
March 1986, illustrates this point:

"Our members are getting beat over the head," says Daniel Hawkins, a policy analyst with the National Association of Community Health Centers. One-third of NACHC's 350 members were notified by Integrity Inc., a New Jersey insurance company, in late 1985 or early 1986 that their malpractice insurance would not be renewed."[9]

The following tells the story of the malpractice insurance problems of the Brownsville Community Health Center in Brownsville, Texas:

"Brownsville paid $21,000 for malpractice insurance in 1985...Then, in July, the center's policy was abruptly cancelled. After a month of desperately searching for a new insurer, Brownsville got a policy with the same company as before at a cost of nearly $200,000, a tenfold increase...To pay the extra cost, Brownsville has cut back its community nurse and pharmacy services, not filled vacant staff slots and refrained from buying new equipment."[10]

Despite all the difficulties, William Doll estimates that there are still about 200 free clinics in the country. They are still very much alive though their character has changed somewhat. Many are less activist than they once were.[11]

"'Most free clinics that survived' says Smith, [David Smith of Haight-Ashbury Free Clinic] 'put service first, politics second. The radical ones had too narrow a base. Free clinics are too financially marginal to survive without building coalitions, without a broad base of support.'"[12]

The free clinics that survived have also developed a workable administrative structure and some kind of a financial base, however meager. Rather than serving adolescent drug abusers, many more now serve the health care needs of the poor and
chronically ill.[13] In so doing, the free clinics have become more similar to community-based clinics and neighborhood health centers. The distinctions between them have blurred considerably over the last 15 to 20 years. Many "free clinics" are no longer offering free services either:

"A number of clinics are no longer free or are wrestling with the financial and philosophical dilemmas of free care in a world where nothing is really free. The Baltimore People's Free Medical Clinic reluctantly dropped 'Free' from its name, though they will turn no one away. The Cleveland Free Clinic, which now has a million dollar budget and operates with a large deficit, is debating whether to accept third-party payments. The Free Health Clinic of Roanoke Valley, which opened in Virginia in 1974, adapted a flexible sliding scale fee schedule, as have several others."[14]

Clearly in this era of budget cutbacks in social spending, the community clinics have been particularly hard hit and a substantial portion of them have closed their doors. However, despite their economic problems, community clinics are not going to die easily. Though they comprise a very small sector of the health care system in the United States, community clinics and neighborhood health centers have turned out to be a much more enduring institution than many would have thought.
Chapter 5
Conclusion

Neighborhood health centers grew out of the War on Poverty and community clinics and free clinics began as part of "The Movement" of the 1960s. Health centers and community clinics were beset by a number of tensions inherent in their structure and position as an alternative to the existing health care system. We have discussed two of the tensions that have been central issues for most neighborhood health centers and community clinics: the role of community participation in governance and the constraints on economic survival.

Taken together, neighborhood health centers and community clinics have proved to be a unique institution for providing comprehensive primary health care services to people who cannot or do not obtain medical care in the mainstream of the private health sector. Health centers and clinics are unique because they have attempted to provide a wide range of social and environmental services that can have a positive effect on health and on the overall social situation in their communities. Many of their founders hoped that health centers and clinics would serve as a basis for initiating broader social change in poor communities.

The issue of community participation in governance of neighborhood health centers encompassed three problems.
First, neighborhood health centers were usually planned and funded without any input from local residents. Also, neither the professionals or local residents had a clear idea of the form that participation should take. Finally, who actually represents the "community" was not always obvious. Clinic organizers frequently ignored the existing community structure.

Community clinics generally appreciated the importance of community participation. However, in the case of free clinics, the clientele often had no interest in taking part in the governance of the clinic.

Efforts at social change are often led by, and probably will continue to be led by, an elite of activists, intellectuals or professionals. It is essential for those of us in academia or the professions who are involved in such movements to remember that any community or constituency will need to determine its own priorities. If we attempt to impose such priorities, however noble and good our intentions, we doom ourselves to problems, just as many of those involved in the community clinic movement realized, and as the founders of neighborhood health centers quickly found out.

In times of economic growth and national concern with domestic poverty, neighborhood health centers and community clinics flourished. However, both health centers and clinics were founded on inherently unreliable sources of funding. Neighborhood health centers were established as demonstration
projects as part of the War on Poverty and community clinics often relied heavily on short term grants and contracts from government and foundation sources. As economic growth declined, our military commitments abroad expanded, and national support for government spending on poverty and social programs waned, neighborhood health centers and community clinics frequently found themselves in dire financial straits. Many health centers and clinics that were bustling in the 1960's and 1970's have closed their doors under these pressures. However, health centers and clinics are far from dead.

The enigma is that so many health centers and community clinics continue to survive despite the changing national ethos and the re-definition of the crisis in health care as the crisis of runaway costs. The clinics that have survived have managed to develop a sound organizational structure and mobilize a strong constituency to aid in solving the never-ending problems inherent in relying on unstable sources of funding. Neighborhood health centers and community clinics have proven to be a small but enduring institution functioning within, and yet in conflict with, the existing corporate health care system in the United States.
NOTES

CHAPTER 1


14. Levitan and Taggart, The Promise of Greatness, pp. 82-93.

16. Levitan and Taggart, *The Promise of Greatness*, pp. 100-101
17. Levitan and Taggart, *The Promise of Greatness*, pp. 119-133

CHAPTER 2


17. Davis and Schoen, Health Care and the War on Poverty, pp. 165-166.


20. Davis and Schoen, Health Care and the War on Poverty, p. 164.


22. Davis and Schoen, Health Care and the War on Poverty, p. 164.


34. Schwartz, "Preliminary Observations of Free Clinics," pp. 147-149.


42. Schacter and Elliston, "Medical Care in a Free Community Clinic," p. 1848.


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52. Schacter and Elliston, "Medical Care in a Free Community Clinic," p. 1851.


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30. Davis and Schoen, Health Care and the War on Poverty, pp. 170-171.


37. Davis and Schoen, Health Care and the War on Poverty, p. 186.

38. Davis and Schoen, Health Care and the War on Poverty, pp. 171, 193.

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42. Davis and Schoen, Health Care and the War on Poverty, p. 172.
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47. Doll, "Whatever Happened To the '60s Free Clinics?" p. 9.


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59. Hayes-Bautista, Primary Care Clinics, pp. 21-23, 40, and 53.


62. Schacter and Elliston, "Medical Care in a Free Community Clinic," p. 1851.


64. Schacter and Elliston, "Medical Care in a Free Community Clinic," p. 1851.


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69. Schwartz, "Preliminary Observations of Free Clinics," p. 188.

70. Schwartz, "Preliminary Observations of Free Clinics," p. 188.

71. Hayes-Bautista, Primary Care Clinics, pp. 16-17, 48.


CHAPTER 4


3. Hayes-Bautista, Primary Care Clinics: Implications of State and County Health Care Policies For Needy and Underserved Populations.


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12. Doll, "Whatever Happened To the '60s Free Clinics?" p. 10.

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